DEPARTMENT OF DEFENSE BLOGGERS ROUNDTABLE WITH GENERAL PETER W. CHIARELLI, ARMY VICE CHIEF OF STAFF; BRIGADIER GENERAL COLLEEN MCGUIRE, ARMY PERSONNEL REPRESENTATIVE; COLONEL THOMAS LANGUIRAND, ARMY SUICIDE PREVENTION TASK FORCE; DR. COL. ELSPETH RITCHIE, ARMY PSYCHIATRIST TIME: 10:30 A.M. EST DATE: THURSDAY, MARCH 5, 2009

(Note: Please refer to www.dod.mil for more information.)

LINDY KYZER (Army Public Affairs): Again, this is Lindy Kyzer with Army Public Affairs. Thank you so much for joining us for this very important roundtable topic.

I'm very pleased to have with us General Peter Chiarelli. He's vice chief of staff of the Army. He's going to be discussing suicide prevention.

Joining him here today is Brigadier General Colleen Maguire; also Colonel Thomas --

COL. LANGUIRAND: Languirand.

MS. KYZER: Languirand. I apologize, sir. And Dr. Colonel Elspeth Ritchie. We're -- we'll go ahead and open to a few minutes of opening remarks from the vice chief of staff, and then we'll take your questions.

Thank you, sir.

GEN. CHIARELLI: Okay. As a leader and human being, I'm deeply saddened each time a soldier loses his or her life, but it is especially troubling when a soldier commits suicide. The culture of the Army is that of a team, and any time one of our own feels so lost that he or she sees no other option than to take their own life, we've failed as an organization.

Unfortunately, suicide is touching every segment of our force: active, reserve and National Guard; officer and enlisted; deployed, nondeployed, and yet-to-be-deployed.

If you've been following the news, you likely saw the coverage of our release of the Army suicide statistics for fiscal year 2008 and then January 2009. Allow me to give you an update on those numbers as they stand today.

As of March 2nd, our figures for fiscal year 2008 stood at 138 soldier suicides, with five still pending confirmation. For January 2009, we had 12 soldier suicides, with 12 still pending determination. And for February 2009, we had two confirmed suicides, with 16 pending confirmation.

This is not business as usual. We must move quickly to prevent further suicides. I've asked all leaders across the force to be personally involved in addressing this issue. Suicide is a multidimensional problem. And as such, we'll take a multidisciplinary approach in dealing with it. We cannot just look at the numbers without also looking at the myriad of factors and reasons that contribute to our problem. There is no single solution for dealing with this challenge.

And that was clear to me yesterday as I sat in a two-hour video teleconference and had 15 cases briefed to me by commanders and general officers -- quite frankly, around the world.

We even talked to folks in Iraq and Korea about cases that they had. It was very instructive and drove home the point that this is definitely a multi-disciplinary problem and that we have to take a multi-disciplinary approach in attacking it.

As an immediate action, we directed an Army-wide stand-down to be conducted within a 30-day window between 15 February and 15 March. We distributed a standardized training support package prior to the start date that focused on the identification of high-risk individuals and intervention. The key to mitigating risk is leadership, starting with first-line leaders and their ability to intervene with soldiers. The stand-down will be followed by a chain teaching program focused on suicide prevention, that allows leaders to communicate with every soldier about this important topic. The chain teach period will run 15 March to 15 July.

We have a number of long-range programs, such as our Strong Bonds program, Battlemind, Comprehensive Soldier Fitness, and our research agreement with the National Institute of Mental Health, designed to address this issue. We're also looking at additional initiatives that could possibly be used for suicide prevention.

Most importantly, we are committed to integrating these programs in a way that helps our soldiers address their individual challenges by seeking help when needed without turning to suicide as a solution.

Brigadier General Colleen McGuire, here with me today, has been designated to head the Army Suicide Prevention Task Force to integrate all of the programs and initiatives into a comprehensive program.

At this time, we'd like to collectively take any questions you might have for us.

MS. KYZER: Carla Lewis (sp) from Some Soldier's Mom, did you have a question?

Q I did. Last year I participated in this call and had asked whether the Army had looked at its crisis intervention and the availability of crisis care -- i.e., weekends, middle of the night. It was my understanding at the time that if a soldier was in crisis, that he reported to the emergency room, absent calling his NCO, which, of course, none of them ever want to do. And is that still the mode of crisis care, is for someone -- for a soldier in crisis to report to an emergency room, or are there other options available?
COL. RITCHIE: This is Colonel Ritchie. Let me take that. There's a number of different options available. Most of them are specific to the installation. For example, every installation not only has an emergency room with behavioral

health on call, but they'll have chaplains and they'll have other resources available.

There is a fairly new VA suicide crisis line which is also open to active duty members. And of course, in theater we have very actively our combat stress control units.

There is a number of civilian resources available to soldiers who are crisis, too -- again, suicide hotlines and other local facilities.

So I think there are resources available to the soldier who's willing to reach out and ask for them. The challenge in many cases -- and I think those on the line are very familiar with it -- is a soldier may not want to reach out and seek help. And that's a bridge we've got to get to to have it be -- the soldier willing to do that.

MS. KYZER: Great. And Chuck Simmins with America's North Shore Journal, did you have a question?

Q Yes. Perhaps -- well, I'm not sure who would answer this, perhaps the vice chief of staff. Is the Army working with the other services, perhaps sharing best practices or coming up with a comprehensive joint approach to this problem? Or is this primarily an Army issue?

GEN. CHIARELLI: Well, I definitely don't think it's just an Army issue or primarily an Army issue. It's an issue for all of us. And I know the Department of Defense is totally committed to doing everything that they can across all the services to drive down the rate of suicide that we're seeing. If you compared the Marines' numbers in 2008 to our numbers, you would see that they are very, very close to one another.

We're working very closely with the Marine Corps and the other services through the Defense Center of Excellence. And we surely are sharing all our best practices and would be more than willing to use any best practices that we can glean from the other services. There's no pride of ownership here with anything that we're doing.

COL. RITCHIE: Colonel Ritchie again. To illustrate that, about three weeks ago the Defense Center of Excellence -- DCOE -- under General Sutton did have a suicide prevention conference which was also with the VA and membership of the SAMHSA -- Substance Abuse and Mental Health Services Administration -- had a lot of family members there. So absolutely, we are working on best practices and sharing those best practices.

Q Thank you.

MS. KYZER: And Bryan Carroll, with A Major's Perspective, did you have a question? Q Yes, Lindy, thank you. Sir, ladies and gentlemen, thank you for taking the time out to do this.

My question kind of goes to the post-deployment side. As kind of alluded to a couple times, during deployment time we have a great system with our combat stress teams, chaplains, other medical facilities and personnel there available to help. And as far as leadership goes, as a leader and both with my NCOs -- I mean, anyone that's not willing to get up at 3:00 A.M. in the morning and take their soldier in if they need help, well, one, I've never quite seen it, but, two, that person doesn't need to be in the position he's in.

But I guess the question goes to when we come back from deployment, both times I've seen the installation went out -- they went out and got contractors to plus-up the number of behavioral health specialists that they had to do screenings, do work with soldiers.

Is there a move afoot to try to institutionalize that across the Army, not just post-by-post taking initiative and doing stuff, but actually to institutionalize that where every BCT, possibly battalions, have the ability that at least during the daytime you have a person that's there in the battalion aid station, that's there within the BCT with the brigade surgeon, to be permanently there at the beck and call of the soldier if need be?

COL. RITCHIE: Colonel Ritchie again. I think you are bringing up two different points. One is a post-deployment screening, which of course we do with the post-deployment health assessment and reassessment; but the other is having somebody, what we call, organic to a particular brigade.

We now have with every brigade combat team either a psychologist or a social worker and enlisted technician assigned to that brigade. And in addition, the chaplains, of course, are assigned to battalions, et cetera. And those people are available.

What we're also looking at is, there's a lot of other brigades that are also interested in having more of their own organic behavioral health assets. And that's something we're looking at, the pro's and con's of doing that.

What we've seen repeatedly throughout different deployments, different wars, is people like to have their own behavioral health person there, or chaplain there, somebody that they know and trust and then are much more likely to go and talk to if there's issues.

GEN. CHIARELLI: But it's important to know that there's no single solution to anything here. You know, I wandered into this believing that if we could get the individual to a mental health care provider, all would be good. Yet, when we look at our suicides in 2008, over 50 percent of them saw mental health care providers, yet still went forward with -- and committed suicide.

I really mean it when I say, the harder I look at this, this is multi-disciplinary, and there is no single solution to working through these issues. They are very, very complicated, and require a multi- disciplinary approach.

I think it's also interesting and instructive to -- to understand that if we look at the 2008 numbers and we break them down, we had about a third, a third, a third: a third that had no prior deployment experience, a third that were deployed when they committed suicide, and about a third that had deployment experience and were back home.

And even when you take that number, the rational person might think that the more deployments, the more likely you are to commit suicide; but we saw exactly the opposite.

A certain resiliency seems to grow in an individual who has multiple deployments, and we actually see the percentage of suicides for multiple deployers much smaller than for individuals who have had a single deployment.

So this is a very, very complicated issue. And we've got to get all the resources available for our soldiers, but there really is no single solution that's going to solve this.

MS. KYZER: Rob Stewart with NCO Call, did you have a question?

Q Yes. We're all agreeing that it's really a leader issue to do as much as they can for identifying the soldiers at risk and helping them find the mental help for these to try to stem this (epidemic, almost ?).

Is the Battlemind training and the suicide prevention training being incorporated into OES and NCOES courses?

COL. LANGUIRAND: Colonel Tom Languirand, Army G-1. Regarding our suicide training, yes. Matter of fact, the stand-down and chain- teach we're doing is being incorporated cross the entire Army, whether it be in the United States or overseas, in theater, and then we're going to have sustainment training that goes on from there, which will be obviously within the various education points, as well as reoccurring at unit levels.

GEN. CHIARELLI: And in the NCOES program.

Q And that's including Warrior Leader Course, BNCOC, ANCOC, Sergeant Majors Academy, all of them across the board?

GEN. CHIARELLI: As far as I know, there will be a component of suicide training in all of them.

Q Okay.

GEN. CHIARELLI: But I need to check those POIs to ensure that -- those programs of instruction before I make a definitive statement like that.

COL. RITCHIE: One of the challenges -- we've had suicide prevention -- Colonel Ritchie here -- we've had suicide prevention training for a long time. The challenge often is to make it fresh and relevant and engaging, and for those -- the "Beyond the Front" video, which is part of our stand-down right now, is the best Army product or the best product I've ever seen in terms of engaging the audience and getting them to talk about some of the issues. And I'm sure it can be improved. All our products can be. But it's really very, very good.

GEN. CHIARELLI: Yeah, I spent five hours with it on -- a week ago Sunday and found it to be some of the best facilitation for training that I've seen in my 36 years in the Army.

(Cross talk.)

COL. LANGUIRAND: I agree. I've gotten the same feedback, from the soldiers that I've talked to, that "Beyond the Front" is an excellent learning tool that they're getting a lot of positive feedback from.

GEN. CHIARELLI: I will tell you that the group that we really, really need to get to are our junior enlisted and junior non- commissioned officers, particularly when you start getting into stigma issues.

I think "Beyond the Front" does a good job of portraying a fact that I'm least coming to, is that we seem to have penetrated many of the higher ranks, in convincing people that there's no stigma to getting help.

It is more difficult, I believe, at the lower levels with junior enlisted and junior non-commissioned officers. And that's an area that we really have to work hard with.

MS. KYZER: And CJ Grisham, Soldier's Perspective, did you have a question?

Q Absolutely.

I'd first like to clarify for the Colonel that we -- I just returned from the First Sergeant Corps a little over a year ago. And it's being trained actively there. I've had soldiers recently return from BNOC. It's being trained there. Suicide prevention, I think, is at every level of the NCOES and has been for a while. So it is being done at the NCOES level for Rob.

My question, I guess, is, and General, this is probably -- you talk about multi-discipline, disciplinary problems with regard to suicide. There's no one answer.

But are we looking at, and what are the -- how do our numbers compare with kind of the civilian sector, in how our current, you know, what I guess people are calling crises are affecting our troops as well, knowing that they're a little bit more susceptible to not only our military stresses but also the stresses of the economy and spouse, jobs and things like that? How do we compare, our rates compare, to the civilian sector?

COL. LANGUIRAND: This is Colonel Tom Languirand in Army G-1.

And obviously as you know in Army, we value every soldier. So one suicide is one too many, regarding comparisons. The civilian rate lags by two years. The Center for Disease Control released their report. It should have been released in February actually. They are having challenges. That would have been their 2006 data.

So we're currently going against 2005 data for an annual rate of 19.5 per 100,000, is the civilian rate. And we're currently on track with our confirmed and pending suicides, for 2008, to be approximately 20.5 percent per 100,000.

COL. RITCHIE: A couple clarifying comments.

One is that that is age-and-gender-matched. In other words in the Army, most of our soldiers are young males. And so we compare that to the civilian young male rate or the civilian male rate.

The other caution I always have, and this is part of my persistent desire to really drive these numbers down, is that in the Army, everybody has a job. They all have access to health care. And they come and screen for a history of psychiatric difficulties.

So what I'd very much like to see personally is our rate come back down to where it was five, six years ago and lower, if at all possible.

COL. LANGUIRAND: I have to agree with Colonel Ritchie. I just want to clarify what we use for a comparison regarding the age. Seventeen to 62 is the age group that we look at against the civilian society. And the gender ratio in the military is 85 percent male, 15 percent female. And that is the rate that we apply against the civilian --

GEN. MCGUIRE: And this is Brigadier General Colleen McGuire and I also wanted to add the fact that we're just now comparing data from really almost in -- a three-year period almost seems like a different era. And so it will be interesting to monitor what the civilian data is compared to where we were in 2008 a few years from now when they catch up as well as it relates to another variable, which is the economy and other outside influencers, because, as we know, there are many factors that go into this. And so therein lies a problem or caution in making these comparisons.

GEN. CHIARELLI: It's always a -- it's probably not helpful at times to give something out of a small sample like I had yesterday when I was briefed on those 15 cases. But a point that was made loud and clear by our Reserve components is they look at the cases that they so far have had this year, that unemployment is a risk factor for them. We saw that constant in the cases that they briefed me on yesterday. This was an individual who was unemployed in civilian life, in the cases that were briefed, and they are now seeing that as a definite risk factor with their population.

Q I'm sorry. That was the Reserve -- excuse me, I'm sorry -- Reserve soldier you were talking about?

GEN. CHIARELLI: I'm talking about both Reserve and National Guard soldiers.

Q Thank you.

MS. KYZER: And Michael Schindler, with Operation Military Family and Military Wire. Did you have a question?

Q I do -- two questions, actually. Number one is how many suicides can be attributed to failed relationships? And number two, what is being done to educate the families of National Guard, because they're so distributed across the states -- what is being done to actually get this information into their hands so that they can maybe watch for signs that they see in their spouses?

COL. LANGUIRAND: It's Colonel Tom Languirand, Army G-1. We have more than a preponderance of our cases attributed to relationships. It's looking right now for the actual percentage -- I believe it's around 60 percent relationships.

COL. RITCHIE: Yeah -- Colonel Ritchie. Historically, it's run between -- I think 60 percent is the most recent figure, and it's -- that's fairly consistent, up to two-thirds (of these ?), three- quarters.

The caveat is often when you look at these cases there's a multiple -- multitude of factors. There's both a relationship problem and a legal or an occupational problem, maybe a substance-abuse problem. And sometimes it's hard to identify what the -- what was the actual precipitant.

But certainly, relationship problems, especially intimate relationship problems, is a major factor.

GEN. CHIARELLI: And the detailed briefings that I received yesterday bear out that analysis. We saw a majority of the cases had a -- at least a relationship problem, but many of them were compounded by other problems, such as a legal issue, a financial issue; and -- but a relationship kind of at the base that had gone bad. So it -- again, it directs us all to a multidisciplinary approach when going after this problem.

COL. RITCHIE: Before you go on to your second question, if I can anticipate a question that I'm sure some of you have, which is how many of these cases have a diagnosis of either post-traumatic stress disorder or of other mental-health disorders.

The number of completed suicides over the last five years who have PTSD -- post-traumatic stress disorder -- is still relatively low. It's -- 5.4 percent have a diagnosis of PTSD over the last five years. But we expect that many more soldiers have had post-traumatic stress issues that aren't yet diagnosed with PTSD.

And then there's a number of other mental diagnoses that I can go into if the group is interested. For example, about 17 percent have a diagnosis of substance abuse.

COL. LANGUIRAND: Colonel Tom Languirand. I'll address the National Guard piece real quick. You know that there's robust family support in the National Guard. Based on their geographic dispersion, they have challenges -- as well as the United States Army Reserve. They have a very robust reintegration program, Yellow Ribbon program, where they look at how they can leverage those community assets that are available. And they also share those with the reserve component, since the reserve component is not state-based. But they help leverage those different resources within the states.

And as an example of how we're approaching this from a multidisciplinary approach, the chief of chaplains yesterday had an off-site to include reserve component chaplains to look at ways that they can improve on their business practices to help folks with spiritual aspects of life to improve relationships, to help us decrease suicides in the Army.

GEN. CHIARELLI: But I will tell you that as I look into this, both the National Guard and the Reserves have a complex challenge in making sure that -- not only training, but families are reached. And you stated it very, very well in your question: the geographic dispersion of units makes that difficult. And we're looking at programs to try to provide assistance to them also. And some of those are online programs that we are looking at right now to be able to deliver to the National Guard and Reserve component.

Q Great. Thank you.

MS. KYZER: And Demi Morrison, with MySideofthePuddle, did you have a question?

Q I do. Thanks, Lindy. This roundtable was very important to me to attend. I've been personally affected by military suicides twice in the past couple of years. One was successful, unfortunately, last year; and one was not, fortunately. So -- but what was common in both cases is the one that was

unsuccessful, when he tried to return to his unit, security clearances had been yanked, so he couldn't do his job. He was very nearly kicked out of the service. And there was a huge stigma around him. He was ostracized by those within his unit.

The one that was successful had reached out to leadership prior to, and experienced the same thing. And he had some other -- he had some other problems. His battle buddy was actually killed earlier in the year, so the one guy that he really felt comfortable turning to was no longer there. But the fact is, leadership let him down.

And I want to know how you're going -- you're planning on addressing that stigma.

GEN. CHIARELLI: Well, I wish we could show you "Beyond the Front" because the -- what you describe is exactly what the "Beyond the Front" video, interactive video that is serving as the centerpiece for our current stand-down, gets at those issues. All that is is training, and it's not going to be solved simply by going through a training session with "Beyond the Front." That's why this is so difficult.

We have to permeate the entire organization, down to the lowest level, in ensuring that all soldiers and civilians realize that some people will not self-refer themselves, will reach out for help. And we have to -- we have to be able to identify those signs and take the appropriate action. And the appropriate action isn't to ask that individual to seek some kind of help; it is to take that individual, to ensure that they seek that help.

So I can -- I can tell you that this is one of the true centerpieces of what we're trying to do right now, both with our stand-down and our change, each, is to get down to the lowest level the absolute necessity to, number one, get rid of the stigma and, number two, know the warning signs so that you can help your buddy. And that's really what we're focused on right now.

COL. RITCHIE: If I could pick up another piece of that -- this is Colonel Ritchie -- you raised the question about the security clearance, and this has been something that we've been working on for quite a while.

And as I think the group is aware, there was a change in the security clearance questionnaire so that you didn't have to report counseling if it was a result of the combat experience. As you all may or may not be aware, the Army wanted to go further on that one. The security clearance is a form that all the different government agencies subscribe to.

It's my personal belief, though, that we still have some work to do to -- there's always a balance, because you want to -- you don't want to do anything to hurt security. You don't want to have people in positions of high authority who shouldn't be there. But at the same time, I really don't want to have people who seek help to have their security clearance pulled as you describe. So we've got some ways to go, I think, before we find the right answer.

Q Thank you.

MS. KYZER: And Mark Benjamin from Salon.com, did you have a question?

Q I do. Thank you for talking with us, General.

I just wondered, what efforts, General Chiarelli, are you making to sort of fact-check the information that you are getting? For example, it sounds like you sat down and drilled down on 15 suicides, but you were briefed by unit leaders, it sounds like.

So if there are cases -- like, we just had a caller -- you know, somebody just said leadership let down a soldier who committed suicide. You know, if there are cases where leadership is dropping the ball or if there are cases where the medical establishment is dropping the ball -- let's say, you know, somebody's being treated as a disciplinary problem when really they have a medical problem -- are you taking -- making any efforts to sort of step outside the chain of command and personally go look at some of these cases without just getting the word from the leaders who, frankly, you know, may not always give you the straight information? GEN. CHIARELLI: I guess the answer to that is yes. We are. And we're looking at standardizing reporting formats to ensure that we are looking at this in what I believe is a way that has proven successful in the past. We're looking very, very hard at the standardization through a -- what we call a 15-6 investigation into suicides, which ensures that we've got people looking at this that are not necessarily in the chain of command.

We're looking very, very hard at our reporting formats to see that we're getting as much information as we can on these cases and at the same time working to break down the different silos that there are -- that grow up amongst agencies. Because it is multi-disciplinary, because you have chaplains involved, leadership involved, mental health care providers involved, you don't always necessarily have the cross talk you need. Silos build up and we're looking hard at breaking those down to make sure that we're coming at this from a team approach.

But yes, we are, in fact, looking at cases to ensure that we can learn everything we possibly can from them. We have got to see ourself here across the board in ensuring that we're learning everything we can from every single case.

GEN. MCGUIRE: This is Brigadier General McGuire. I -- it was very revealing to me when I was listening to the feedback that we were receiving from the leadership that they truly were self-critical and that trying to get through where did -- where could we have done better and where could we have served the soldier better or to share our lessons learned so that although that particular command or other commands listening in may not have experienced that particular event or the events that -- incidents that led to that event, they could learn from it.

One of my charter is to truly look across these silos, as General Chiarelli just articulated, and look to where -- to ensure that they're integrated and synchronized across all disciplines so that in the end, that leader, that commander can have a menu of tools, of training programs, experts that he can turn to and know how to best employ them or a combination, in order to deal with the unique and individual needs of these individuals.

Because it's never going to be, as was already stated by General Chiarelli, it's not a single; we cannot -- we don't have a single solution. But we've got to be able to, through all disciplines and all the hard work out there, try to figure out how best to support the needs of these individuals who are in pain.

MR. : You know, the real value of what we did yesterday was having all the commands up and listening to the experiences of the other commands. If you have a single experience or a couple experiences, your tendency will be to only institutionalize those lessons that you've learned from those experiences.

But when commands from all over can hear different instances and what happened in those instances, where an individual committed suicide, you have the power of spreading those lessons learned throughout the entire force. We did that yesterday. And we will also follow it up in writing, to ensure that they get pushed down to the lowest levels within our formations.

MS. : Mark, you brought up one other thing, which I'd like to highlight on, which was the question about whether medical problems were confused with disciplinary problems. And I know you've written on that extensively.

As you're aware, because we sent it to you, we issued a policy, in May of 2008, to make sure that any soldier who was receiving an administrative separation for anything bad, whether misconduct or a personality disorder or whatever, be specifically screened for post- traumatic stress disorder and traumatic brain injury and any other psychological problems that might be contributing to the disciplinary problems.

So that policy was instituted last spring. And we continue to look very hard at those discharges, to make sure that we're not missing anything.
MS. KYZER: And Karen Francis with Parents Zone, did you have a question?

Q I have a question and a couple of comments. One of my comments is I've been through the Yellow Ribbon program. It's great if it works, but often there's just not enough people. It becomes a check off the box. And a lot of it is chaplain-driven. There are a lot of people who have no religion and feel awkward about talking to a chaplain, so I just wanted to bring that out.

My question is, how can parents help? Because when that -- when the relationship goes sour, when the marriage breaks up, the engagement, whatever, they come home to mom. Now, what can mom do? Because we aren't always the next of kin, we are not the, quote, "family member," we can see things in our children that perhaps no one else is. How can -- and I'd like to put as many links on my site as I can for parents -- how can mom and dad or sister and brother, who are seeing this, get hold of someone so that this soldier is looked after?

Q Yeah, Karen, I want to add to this. You know, we had this conversation about opportunities for single soldiers, that the parents are left out of the loop, and we understand that that's a problem, but that information is not getting back to the people who deal with the fallout, I mean in terms of the parents. This is where soldiers -- single soldiers come home to.

Q Yep.

DR. COL. RITCHIE: This is Colonel Ritchie. I have a partial answer for you, but I think that's something that we really need to think about more. You're right, I believe, that you often don't know what to expect. And there are educational materials -- and there's a lot of educational materials out there -- go to the nuclear family members and our health care services go to

beneficiaries, but what you're saying is not just how can we educate you, but how can you educate us?

One of things I've seen that I've been a little dismayed by is at times I'll get a letter from a congressman and it's written from the mother of the parent -- mother of a soldier, and they're concerned about their soldier, and I get the letter two months after the concern, and I say, well, wait a second; I wish I'd had this information sooner because if there's a concern, we pick up the phone or we make the e-mail and we connect and make sure the soldier is taken care of. So that's not a complete answer at all to your question, it's more of an acknowledgement that I think there needs to be a better partnership there.

Q Because sometimes, to be honest with you -- I'm an Army wife too -- when a parent calls the hospital and says, my kid is -- you know, he's in danger here, you're asked for your ID card. You're asked, well, are you the next of kin? And if you're not, well, you know, we can't help you. And that just -- that has to -- that has to stop and it has to -- the hospital has to realize that you're not calling to get this guy in because he stubbed his toe. And there's my -- there's the dilemma for parents. We aren't official, but if anyone knows that kid as well as I do, it might be his dad but it sure as heck isn't his first sergeant.

MS. KYZER: Can we take that one as a do-out? General Chiarelli?

GEN. CHIARELLI: But I would argue that you almost have to do the same thing that any one of us has to do, and that is not stop with the hospital. If the hospital isn't helpful in getting you through that -- and we had a case yesterday that was briefed to me where a crisis hotline wasn't helpful. I am very concerned with the proliferation of crisis hotlines. Everybody wants to have one right now and some of them are better than others. Some of them literally have prompts that you have to go through that are like the bad ones that we have all had to call up to when you have a problem with your phone service or something. And that came out in one of the cases that was briefed yesterday, and it was a parent -- a parent who had gone ahead and used a crisis hotline, only to get a series of prompts.

What that parent did in this particular case -- and they were successful in intervening, not successful in the end -- is they went away from the crisis hotline and went to a commander. And I hope that our commanders who are out there would be much more willing to assist and take information from a parent than maybe the person who picks up the phone at a hospital and is not as forthcoming with assistance.

But one of the things that we're training our folks to do is don't leave it up to the individual and don't stop at the first place you go and don't necessarily get the response that you need. We want to ensure that there are multiple avenues to get that help that you need.

Q And, sir, there's one little caveat to that, is a lot of times the parents don't know who the first sergeant is. They have no information. They might be lucky to be in a VFRG, but when my son was in, he was based out of First Armored in VSPTN (ph). I couldn't have told you the name of that first sergeant for love nor money, and I've been an Army wife for 25 years. So that kind of information doesn't always trickle down to us, so if there could be -- I don't know. It's so hard to get information out without violating OPSEC, we understand that, but I think Carla (sp) and I are both on the same page that

there needs to be more acknowledgement that parents are seeing it, and when they call up they're not just blowing smoke.

Q If nothing else, parents need to be looked at as an additional resource, and my suggestion for the Army and other services are is that every point of contact with the parent, whether that's at their induction -- when they enlist they're in touch with recruiters and most of them, or at least a fair majority of them attend graduation and that. But information should be handed out both points in time on how to recognize changes in your soldier, you know, where there is a point in the chain of command at their base and even if it's just, you know, whatever unit they're going to, that that's at least a basic information provided to parents, because when my son was in the only thing I knew was that he was at Fort Benning, Georgia, and I could tell you his battalion and his unit, but I couldn't have told you the name of anybody -- couldn't have told you his platoon sergeant, I couldn't tell you his company commander. I didn't know those names but I knew where he was.

MS. KYZER: And thank you for that, Carla, and thank you, Karen. I'm afraid we're just going to have to move on to other questions but we will take that information. We do know your concern about getting more information out to parents.

GEN. CHIARELLI: And I appreciate that input because that's something we'll take a hard look at.

Q Thank you.

MS. KYZER: And I know that there are other folks on the line who I haven't yet given the time to ask a question, so if you're on the line and I didn't announce your name and you have a question, please jump in now.

Q Hello, it's Pauline Jonak (ph). I wanted to clarify something on -- well, with General Chiarelli, who spoke about suicides, unemployment among reservists. And to clarify, are you saying that this is the first time that effects of a nation's economic crisis are showing up this definitively as a factor in Guard suicides, or can you sort of clarify what you meant?

GEN. CHIARELLI: No, I'm saying --

Q No? Okay.

GEN. CHIARELLI: -- that in the small number of cases that I had yesterday -- and it was a small number and that's why I cautioned my remarks by indicating that it's always difficult to use a small number and come up with any kind of truth. But it was brought up by the briefers as they looked at lessons learned that economic issues were something that they were seeing in that small number of cases that they looked at.

Q Okay, and to clarify something on the January versus February figures, my recollection is that the January number was of special note, not just because the raw number was so high -- it was 24 suspected -- but that it was high compared to year over year, the usual January numbers. Can you give us sort of the same sense of what February over February was, and answer is that a meaningful way to do it or no?

COL. LANGUIRAND: Ma'am -- this is Colonel Languirand -- January was an extremely high month, very disturbing. February, it's a high month; it's very

disturbing. We're doing -- we're taking every effort that we can think of doing. We're having various forums that we haven't had before, conducting training across the entire organization. Nobody is satisfied where we are with our suicide prevention program right now, and it's disturbing. The numbers are higher than they were last year, yes, ma'am.

MS. KYZER: Did that answer your question?

Q I'm sorry, so you don't think it makes sense? I mean, may we have the like February '07, February '08 number, or is that not a meaningful thing to do, because that's how it was done in January. It was something --

DR. COL. RITCHIE: Pauline, Mr. Morales will take that.

MR. MORALES: No, I don't --

(Cross talk.)

DR. COL. RITCHIE: Oh, you don't have that information?

MR. MORALES: No, I do not.

DR. COL. RITCHIE: Well, we could get that, couldn't we? MR. MORALES: Well, we can get that, you know, but we have the year to date, like Colonel Languirand just said, but she's asking more compare Feb. to last February's --

COL. LANGUIRAND: Well, we have --

DR. COL. RITCHIE: We have --

COL. LANGUIRAND: Last February was 11.

DR. COL. RITCHIE: And, this February, two confirmed and 16 pending.

COL. LANGUIRAND: And 16 pending -- 18, yes. It's higher. It's disturbing. And we're trying to do everything that we can. I'd love to tell you that February was zero. I hope we can come back and tell you that March is zero, and April. We're trying to get this number down, using as many approaches as we can as quickly as we can across the organization.

Q But my question goes to, does it make any sense to do sort of a seasonal -- is there a difference month to month, you know what I mean? And 11, you mean, was confirmed in 2008? Is that what you mean, 11 confirmed in 2008 February?

COL. LANGUIRAND: Ma'am, and we looked at this over a few-year period, and we see that spring/summertime is higher than actually around traditional holiday periods. And it isn't that far out of the norm that we would say that it's an extreme high period, it just appears to rise during that period.

DR. COL. RITCHIE: Pauline, let me answer your question -- this is Colonel Ritchie -- in a slightly different way. If you're asking about seasonable variability, there is a belief that suicides go up around the holidays. When we look at our figures we don't see that. As Colonel Languirand mentioned, traditionally it's higher in the summer months. And when I look at the individual cases, I believe it's because that's a time of transition -- a lot of PCSs, a lot of moves, and in some cases these suicides happen between

PCSs and moves. But there is not a clear seasonal "aha," this is a really critical time period for these.

Q Okay, and just, again, these 11 for February of '08 was 11 totally confirmed.

COL. LANGUIRAND: Correct.

Q Thank you.

MS. KYZER: Okay, anyone else on the line who has not yet asked a question? We're going to have to close up pretty soon here.

Q Can I make a comment? MS. KYZER: Yeah, real quick, C.J.

Q Just really quick. I apologize. I'm going to step out of my blogger hat and put on an NCO hat here. I think it really boils down to what the General was talking about earlier, which is leadership. As a first sergeant I'm one of the guys that was taught that when you get new soldiers in, you call those parents and you call their family members, and you intimately know who they are and make them aware, and it's something that I still do. I just think it's something that we need to focus on with leadership in the Army. We are focusing on it not only at the Army level but here at the company levels, and it's just something that NCOs and officers need to really start taking an active interest in their troops.

MS. KYZER: Thanks, C.J. With that -- and, again, we're going to have to close the round table. Than you all for very good questions. A lot of good information came out. Thank you very much.

General Chiarelli, did you have any closing remarks, or did you want to close us out, sir?

GEN. CHIARELLI: I just want to say that we are focused on this and are going to do everything we possibly can to drive these numbers down. But this is one of the hardest problems I've seen in 36 years, and as I dig deeper and deeper into it and define how we're going to do that, it is extremely difficult. But I would just like to emphasize what the first sergeant said. Leadership is that single issue that I believe is absolutely critical to getting at this. And for a long time the Army did well when compared -- and I'm not necessarily of the belief anymore that those comparisons are worth anything, but we did well when compared with the civilian averages. And I believe that that was because we probably weren't as stressed of a force as we are right now. We had additional time to do the kinds of things that we need to do, and we just need to make sure that we're letting every one of our leaders know the need to take appropriate action when they see any of the signs emitting from their soldiers that might indicate that they are depressed or contemplating suicide. That is the key, I really believe, to solving this issue.

Thank you very much.

MS. KYZER: Thank you.

MS. : Thank you.

MS. : Thank you.

MS. KYZER: Thank you, General McGuire. Thank you, Colonel Ritchie and Colonel Languirand. And this concludes the roundtable.

GEN. CHIARELLI: Thank you. MS. : Thanks.

END.